PHARMACY BENEFIT

Prescription drug charges are payable only through the Plan's Pharmacy Benefit Manager (PBM) program, which program is sponsored in conjunction with and is an integral part of this Plan.

Specific information regarding Copayments, Coverage, Service Options, Limitations and Exclusions are stated as follows under this section. **The Pharmacy Benefit Manager (PBM) will provide separate information for details regarding Network pharmacies and Preferred Brand prescriptions upon enrollment for coverage under this Plan.**

"Copayment" means a dollar amount fixed as either a percentage or a specific dollar amount per prescription payable to the pharmacy at the time of service. **Copayments are not payable by the Plan and do not serve to satisfy the Medical Benefits Annual Deductible or Out-of-Pocket Maximum.**

The Copayment is waived if generic prescriptions are obtained for Maintenance Therapy Drugs. A complete list of generic Maintenance Therapy Drugs may be obtained from the Pharmacy Benefit Manager. The Maintenance Therapy Drug list may also be referred to as "Preventive Therapy Drug List" by the Pharmacy Benefit Manager.

PBM Network Prescriptions	**Copayment per Prescription**
Generic	$10
Preferred Brand	$25
Non-Preferred Brand	$45

Member Submit Prescriptions	**Copayment per Prescription**
Generic	$10
Preferred Brand	$25
Non-Preferred Brand	$45

The PBM will reimburse the contract cost of the prescription drug, less the applicable Copayment per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription.

Mail Order Prescriptions	**Copayment per Prescription**
Generic	$20
Preferred Brand	$50
Non-Preferred Brand	$90

When Primary Coverage exists Under Another Plan

If primary coverage exists under another plan, including Medicare Part D, charges for prescription drugs must be submitted to the primary carrier first. Once this Plan receives a copy of the drug receipt or explanation of benefits showing the total charges and amounts paid for eligible prescription drugs from the primary carrier, if applicable, this Plan will reimburse the Participant for the remainder of Eligible Expenses, subject to the following Copayments:

Generic	$10
Brand Name	$25

In order to receive reimbursement, the drug receipt must be submitted to Allegiance.

COVERAGE

Coverage for prescription drugs will include only those drugs requiring a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, and that are Medically Necessary for the treatment of an Illness or Injury.

Coverage also includes prescription drugs or supplies that require a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, as follows:

1. Self-administered contraceptives.

   Contraceptive Management, injectable contraceptives and contraceptive devices are covered under the Medical Benefits of this Plan.

2. Legend vitamins (oral only): prenatal agents used in pregnancy

3. Diabetic supplies, including syringes, needles, insulin injectable devices, swabs, blood test strips, blood glucose calibration solutions, urine tests, lancets, and lancet devices.

   Blood monitors and kits. Blood monitors and kits are also eligible for coverage under the Medical Benefits, subject to all provisions and limitations of this Plan.

SERVICE OPTIONS

The Program includes the following Service Options for obtaining prescriptions under the Pharmacy Benefit:

PBM Network Prescriptions: Available only through a retail pharmacy that is part of the PBM Network. The pharmacy will bill the Plan directly for that part of the prescription cost that exceeds the Copayment (Copayment amount must be paid to pharmacy at time of purchase). **The prescription identification card is required for this option.**

Member Submit Prescriptions: Available only if the prescription identification card cannot be used because a pharmacy is not part of the PBM Network, or the prescription identification card is not used at a PBM pharmacy. **Prescriptions must be paid for at the point of purchase and the prescription drug receipt must be submitted to the Pharmacy Benefit Manager (PBM), along with a reimbursement form (Direct Reimbursement). The PBM will reimburse the contract cost of the prescription drug, less the applicable Copayment per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription.**

Mail Order Prescriptions: Available only through a licensed pharmacy that is part of the PBM Network which fills prescriptions and delivers them to Covered Persons through the United States Postal Service, United Parcel Service or other delivery service. **The pharmacy will bill the Plan directly for prescription costs that exceed the Copayment.**

Specialty Drug(s): These medications are generic or non-generic drugs classified by the Plan and listed by the PBM as Specialty Drugs and require special handling (e.g., most injectable drugs other than insulin). Specialty drugs may be obtained from a preferred specialty pharmacy. **A list of specialty drugs and preferred specialty pharmacies may be obtained from the PBM or Plan Supervisor.**

DRUG OPTIONS

The drug options available are:

Generic: Those drugs and supplies listed in the most current edition of the Physicians Desk Reference or by the PBM Program as generic drugs.

Preferred Brand: Non-generic drugs and supplies listed as "Preferred Brand" by the PBM Program as stated in a written list provided to Covered Persons and updated from time to time.

Non-Preferred Brand: Copyrighted or patented brand name drugs (Non-Generic) which are not recognized or listed as Preferred Brand drugs or supplies by the PBM Program. On limited occasions a Generic may be included when specific regulatory or market places circumstances exist.

PRIMARY COVERAGE UNDER ANOTHER PLAN

When primary coverage exists under another Plan, including Medicare Part D, charges for prescription drugs may be reimbursed by the Plan as specifically stated in the Schedule of Medical Benefits, subject to the following conditions:

1. The prescription drug receipt and explanation of benefits from primary carrier (if applicable) is submitted to the Plan, along with a reimbursement form to Allegiance Benefit Plan Management, Inc..

2. The pharmacy indicates either "generic" or "brand" on the prescription drug receipt.

3. The primary coverage information has been previously submitted to the Plan.

Charges for prescription drugs are not eligible if the above conditions are not met.

QUANTITY LIMITS

Supply is limited to 34 days for Member Submit and PBM Network Prescriptions or a 90-day supply for Mail Order Prescriptions.

EXCLUSIONS

Prescription drugs or supplies in the following categories are specifically excluded:

1. Cosmetic only indications: Photo-aged skin products (Renova); Hair Growth Agents (Propecia, Vaniqa); and Injectable cosmetics (botox cosmetic).

2. Dermatology: Tretinoin agents used in the treatment of acne and/or for cosmetic purposes (Retin A) for Covered Persons 20 years or older.

3. Depigmentation products used for skin conditions requiring a bleaching agent.

4. Contraception: Injectables, implants, diaphragms, IUD's and Emergency.*

5. Fertility agents, oral, vaginal and injectable.

6. Impotence.

7. Weight management.

8. Allergens.

9. Serums, toxoids and vaccines (all dosage forms including injectable).

10. Legend vitamins, except as specifically covered.

11. Legend fluoride products

12. Legend Smoking Cessation products.

13. Diabetic pump supplies.*

14. Durable Medical Equipment.*

15. Experimental or Investigational drugs.

16. Compounded pharmaceuticals containing bulk chemicals.

*Eligible for coverage under the Medical Benefits, subject to all provisions and limitations of this Plan.

NON-FORMULARY EXCLUSION

Certain drugs may be excluded by the Plan's Pharmacy Benefit Manager (PBM). Those exclusions are based upon the PBM's clinical research regarding the efficacy of the drug as compared to other similar drugs, the availability of the drug, and clinical prescribing rules. Drugs excluded under this basis may be covered if a request for Prior Authorization is made, or if a denial of coverage for the drug is appealed under the claims and appeals procedures of this Plan.

SCHEDULE OF VISION BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

Vision Examination (applicable for spectacle lenses or contacts lenses)
Exam limited to once each 24 months, up to $50

Materials

Lenses, Frames and/or Contacts once during any 24 months
up to a Maximum Benefit of $300.00